FISCAL SYSTEMS IN NEGRO PRIVATELY-OWNED HOSPITALS IN GEORGIA, FLORIDA AND ALABAMA

A THESIS

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF CHARTS AND FIGURES

Chart — Page

Figure

CHAPTER I

HISTORICAL BACKGROUND

The history of the hospitals studied dates back to 1901 when the first one was opened.[1] Seemingly, no definite period can be considered as the era of Negro private hospital origin. The newest member of this group was started in 1945. They all opened their doors after the beginning of the 20th century, with two being established in 1928. In none has there been any great expansion. When additional space is needed, the tendency has been to make use of adjoining or close-by dwelling units. This was done in three instances, and in each instance, the property had previously been acquired by the hospital and rented out until needed. In each case, the dwelling has been maintained in such a way as to make it convenient to reconvert it to private use should it be no longer needed for hospital purposes. One of the institutions studied is now constructing an addition which is to be used as part of the hospital, but may at any time be converted to private use. One hospital has done some major addition to its main structure within the last ten years, and it added a basement unit to give additional space for offices and clinical services.

As private hospitals, these institutions do not receive aid from the local, state or federal government. Further, gifts from the general public represent only a small fraction of their plant value.[2] Mainly, these hospitals are products

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[1] See Table 6

[2] Ibid.

and property of individual men or families.[1]

Purpose of This Study

The purpose of this study is to analyze the fiscal systems of the Negro privately-owned hospitals in Georgia, Florida and Alabama, in light of accepted accounting principles. Another purpose is that of comparing these systems with the uniform system of hospital accounting advocated by the American Hospital Association.

An effort has been made to discover if there are any practices peculiar to Negro privately-owned hospitals. Specifically, the following questions were uppermost in the mind of the student:

1. Amount of training of persons responsible for record-keeping in units studied.
2. Scope of accounting systems in use.
3. Working capital.
4. Pricing of drugs, dressings and services.

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[1]See TABLE 6

Racial Influence

In order to better understand the reasons for the types and inadequacies of the fiscal systems used in Negro privately-owned hospitals in the states studied, it is necessary to know something of the present makeup of these institutions. The Negro privately-owned hospital anywhere is a direct result of one or more of the following:

1. A desire of a physician or a group of physicians for a place where he or they may continue to treat the medical patient after he has been admitted to a hospital for institional care.

2. A desire of a physician or group of physicians for a place in which to perform surgery.

3. A desire of the Negro population for a place where they may go for medical and surgical care and be treated with respect and by the physician or surgeon of their choice.

It is also one or a combination of these reasons that keeps the Negro private hospital operating against odds once it is established.

Although race prejudice gave rise to Negro privately-owned hospitals, the cooperation of the white physician plays a major role in keeping them operating. This is due to several reasons. In some instances, the white physician is geniunely interested in the progress of the hospital and goes out of the way to help it. Again, he finds the informality, less rigid schedule and easier access to the operating room to his liking.

CHAPTER II

FISCAL RECORDS

Admission cards.--The procedure for admitting new patients is practically the same for all the hospitals studied. The patient is sent to the Business Office and there gives information concerning, among other things, responsibility for payment of his or her hospital bill. It is at this time that the fiscal records for the particular patient are started. All of the hospitals studied, use admission cards upon which the following financial data is entered: price of room or ward service, name and address of patient, name and address of person responsible for hospital bill, occupation and in some cases, name of employer. Two of the hospitals give to the prospective patient a small sheet containing an estimation of his hospital bill and methods of payment.[1] The officials of these particular units found that often the patient upon discharge claimed he had no knowledge of financial requirements.

The admission card is then placed in a current file (for patients now confined to the hospital). Here, the uniform use of the admission card ends. In two of the hospitals studied, the admission card is not used again until the patient is discharged. In one of these, the patients' room and board, operating room, anesthesia, drug, dressing and miscellaneous

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[1]See Figure 1

charges are figured on the back of the patient's chart at the time of discharge. If the patient pays his bill in full, the chart is marked "paid" and filed in the medical records section --completely separate from the financial records. If a balance is present, it is transferred to the admission card. In the other hospital using the same method, the entire charges (total) are transferred to the admission card, and the total payment is entered. The balance, if any, is shown in a column provided for same.[1] One hospital makes daily use of the admission card to keep a running record of charges to patients' accounts. Each day, the patients' charts are consulted and charges are entered on the admission card for board and room, all services. At the latter unit, it is possible to tell the patient at any time what his bill is.

In all of the hospitals, the admission cards are handled the same upon discharge of the patient. If the patient is discharged owing a balance, his card is placed in the "unpaid" file. If his bill is paid in full, the card is filed in the "paid" file.

Generally, there seem to be no separation of cards according to length of indebtedness. Cards are filed alphabetically and the balance on one card may have been due for six months, while the balance on the next card may have been due for only six days. In only one hospital was there a more detailed breakdown of the "unpaid" file. Here, the file was separated into twelve month periods, and into patients responsible for

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[1]See Figure 1

for their own bills, patients for whom some firms were responsible, and patients for whom physicians or reliable persons were responsible.

In only one of the hospitals is there a readily accessible breakdown of patient charges. This is found on the front of the admission card.[1] Incidentally, while the other admission cards are made to order with the hospital name at the top, this card is mass produced by a hospital record company and sold at a reasonable price. Items charged are listed under their proper headings, such as room and board, anesthesia, operating room, drugs, dressings and miscellaneous. At the end of the fiscal period, it is only necessary to extract the figures for each type of service in order to obtain the total for the year.

Two other hospitals have this information recorded on the patients' receipt and the receipt stub. This, apparently, causes confusion when and if the yearly total is sought, inasmuch as many of the patients are issued two or more receipts and duplication arises as the same information is recorded more than once.

Patient's Chart.--While the patient's chart is principally an instrument for the use of the nurses, and doctors in treatment of the patient, it is the foundation of the patient's financial records. Here, all charges originate, with the exception of long distance telephone calls made or telegrams sent from the Business Office. Here, the doctor gives the

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[1]See Figure 1

orders for drugs and services to be given the patient. Here, these drugs, their strength or amount and number of doses or injections, and special services are recorded. These recordings form the basis for medical and service charges.

All of the hospitals studied use chart forms basically alike, and adequate for recording necessary information.

As an additional aid to the financial section, one hospital employs a cardboard folder as the first and last sheets of the chart. On the front of this folder is space for recording the name and address of persons responsible for the patient's hospital bill. This is essential when patients are admitted after the Business Office is closed.

Receipt book.--In all but two of the hospitals, the receipt book is the only record of patient income. Several of the hospitals have their receipt books made to order for their needs. Two find it just as convenient to use the ones sold by hospital record companies. The receipts are numbered consecutively and the books are filed by number and dates when filled.

In the two hospitals with additional record of patient income the payments along with the patient's name, are transferred from the receipt book to a cash receipts journal and totalled each month. According to the administrators, this method facilitates verification of payments in case of misunderstanding without searching through the receipt books page by page. It also serves to give a condensed picture of collections by the day, week or month.

General records.--Hospital C has the most compete system of the group. It consists of a combination cash disbursements and accounts payable journal, a general journal, a general ledger, a cash receipts book and a petty cash book.

1. Combination Cash Disbursements and Accounts Payable Journal - a twelve column entry book with explanation section on both sides of the page. With the book open, the accounts payables for the month are recorded on the left hand page, and cash disbursements on the right hand page. This arrangement is possible because of the comparative small amount of entries and the thirty lines to each page.

On the accounts payable sheet, in addition to the credit column, there are debit columns for the dietary expenses, drugs, operating room supplies, laboratory, heat, light and telephone, administrative and miscellaneous. These columns afford a complete breakdown of charges, with housekeeping, laundry and other sundry expenses being identified individually in the miscellaneous column. Invoices containing charges for two or more departments are broken down and the appropriate charge made to each department. For instance, invoices from the wholesale grocer often contain food items, cleaning supplies and toilet tissues. This necessitates charges to both dietary expenses and housekeeping. The same is true of invoices from surgical houses. They often contain charges for general drugs, housekeeping supplies, laboratory supplies and operating room supplies.

Purchase discount periods are listed on the accounts payable sheet, but in such a manner as not to be confused with the monetary figures. With the usual discount period ending ten days from the first of the month following purchases, it is convenient to just glance down the page and pick out the invoices to be paid within the discount period.

The cash disbursements page contains, in addition to the credit columns, columns for the following; discounts, accounts payable, dietary expenses, administrative, hospital services, and miscellaneous. The hospital services column serves mainly as a reduction in patient income inasmuch as mostly refunds to patients are recorded in it. The dietary expenses column is maintained because of the frequency of cash purchases from a variety of sources not having accounts in the general ledger. Maintenance and other infrequent expenses are recorded in the miscellaneous expense column.

2. Cash Receipts Book - a two column journal is used and entries from the receipt book are entered in chronological order, giving the following information: date, last name and first name of patient, and amount collected. The money column is totalled at the end of each month and the total transferred to the hospital services account in the general ledger.

3. Petty Cash Book - a flexible back book of the variety sold in the 5 & 10¢ store, in which all cash expenditures of less than twenty-five dollars are recorded.

Of the seven hospitals included in this survey, five maintain full sets of bookkeeping records, while two only keep cash receipts books and cash disbursement books.[1] Only two hospitals employ full-time trained bookkeepers, four make use of untrained personnel and two others use trained part-time bookkeepers. In only four instances, are petty cash books used. The three administrators who do not use the petty cash book, likewise, do not keep accurate record of small cash purchases.[2] Two of the units operate as nearly as possible in accordance with budgets prepared at the beginning of the year.

Allowance for depreciation for buildings and equipment, is part of operating expenses in only two hospitals. Four administrators purchase equipment from earnings as needed or as the funds are available. The others make no provisions for replacement of building and equipment.

In keeping with the requirement set forth by the federal government, four of the hospitals employ certified public accountants to prepare the Hospital Statement of Reimbursement Cost.[3] Two others have their statements prepared by employees and certify that they are unable to obtain the services of certified public accountants. One hospital has never submitted a cost statement, and is paid a flat rate of $5.00 per diem for

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1 See Table 7

2 See Table 8

3 See Appendix

each patient sent in by the participating agencies.

Three hospitals file no tax reports; two have theirs prepared and filed by certified public accountants and two file their own which are prepared by employees. In five instances, the records are checked periodically by outside accounting personnel. Only one of these five administrators feels that his records are adequate; while of the two whom records are not checked by an outside source, one feels that his records are adequate.

CHAPTER III

WORKING CAPITAL

In its present common usage, "working capital"is the excess of current assets over current liabilities. According to the manual put out by the American Hospital Association, "working capital" in hospital accounting is that portion of the hospital's capital which is available for general operating purposes. There seems to be no disagreement between the two definitions, merely a differ manner of stating the same thing. "That part of the hospital's capital which is available for general operating purposes" is equal to the current assets minus the current liabilities.

Among small hospitals, it is common practice to figure their statements on a cash basis, taking in consideration accounts receivables, only when they are collected. The reason advanced for this is that these small private hospitals request and demand that the patient's hospital bill be paid before discharge. Only in a few cases is the patient who is responsible for his own bill or whose family is responsible for the bill, allowed to leave the hospital before the entire amount is paid. In cases, where federal, state or local agencies, or firms are responsible, the cash is collected within a relatively short time after the patient is discharged. It has been found that the patient who is unable to secure enough money to pay his hospital bill before discharge, is rarely able to pay, or rarely pays it after discharge. In cases where payment is made, it is within a short time. With this in mind,

the Negro private hospitals are not concerned with the "working capital" ratio, but the cash to current liability ratio.[1]

For reasons best known to themselves, administrators of the hospitals studied were reluctant to give information pertaining to their "working capital". In the one instance where this information was obtained, the cash to current liability ration was approximately 5 to 3. This particular hospital did not ever list accounts receivables on its balance sheet at all. While this has the effect of denying the asset, this method is acceptable to the various agencies sending patients to the hospital on a reimbursable cost basis.

While accounts receivables are denied by the hospitals operating on a cash basis, they form an important part of the financial structure. No matter how efficient the office is in collecting charges before the patient leaves, every hospital has accounts receivables incurred or acquired through various means, such as accident cases admitted without definite financial arrangements, patients who renege on their promise to pay the bill before leaving, and patients allowed to make credit arrangements upon entering the hospital.[2]

Handling of these accounts directly affect the revenue and "working capital" of the hospitals. In one hospital, the administrator makes personal calls at the homes of delinquent debtors. According to him, this is a better method than "billing" in that it gets an immediate answer to the question, "when are you going

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[1]This information was obtained through personal interviews with five administrators of hospitals included in this study.

[2]See Table 4

to pay this outstanding account?". In some cases, collections have been made on the spot. It isthe consensus of all the administrators, that prompt attention to accounts as soon as they are overdue increases the chances of collection. Hospital E mailed one hundred collection letters to delinquent debtors with accounts three months or more overdue, and received only two replies, one resenting the implication that the bill would not be paid, and the other stating that the payment would be made as soon as the debtor was able.

> Where business often bears down hardest to collect its bills, most hospitals, take it easy.
> This policy is consistent with the nature of the hospital's work. Besides, in the opinion of one man who has had twenty years' successful experience collecting hospital bills, it is the best possible way to make sure of collecting the full amount of the hospital's charges.
> People are sensitive about the bills they owe and they are quick to take offense at any imagined insult in a collection letter or telephone call. Once a person gets angry, justifiably or not, your chance of collecting your bill just about disappears.[1]

All of the administrators contacted agreed with the above statement, but emphasized that every possible effort must be made to collect all accounts as the existence of the small private hospital depends almost wholly and solely upon patient income. No longer are small hospitals the recipients of large sums of money that enable them to operate at a deficit and still keep their doors open to the public.[2] The present tax structure has cut down on philanthropy of all kinds. Also,

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[1] Small Hospital Forum, "Collections Do Them Credit", The Modern Hospital, LXVI (April 1946) 82

[2] See Table 6

according to one administrator, "there have been instances in which bequeaths have been made to provide health facilities for Negroes, and the heirs to the will have found ways of getting around these provisions".

Of nineteen white private hospitals polled by the Small Hospital Forum of the Modern Hospital Magazine, seventeen reported that they ultimately turn delinquent accounts over to collecting agencies.[1] One merely continues to send collection letters and hope for the best. The other sets up a reserve of 4% for bad debts and considers it part of the operating budget. They have found that this amount is sufficient to cover all bad debt losses. This same hospital offers a cash discount of 5% on room rates for payment before leaving the hospital.

Of the hospitals polled in connection with study, all but three have at one time or another made use of collecting agencies. Those administrators who made use of collecting agencies were unanimous in their assertions that this method is not at all satisfactory. Two went so far as to state that the use of collecting agencies was detrimental to the hospitals' well-being. They claim that collecting agencies merely antagonize persons who were unable or had no intentions of paying their bills. These persons, they assert, in turn seriously damage the reputation of the hospital through malicious and wilful lying.

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[1]Small Hospital Forum, "Collections Do Them Credit", The Modern Hospital, LXVK (April 1946) 83

CHAPTER IV

PRICING OF DRESSINGS, DRUGS, AND SERVICES

The present practice in the hospitals studied is for an extra charge to be made for all drugs and dressings used, rather than an inclusive room charge which covers these costs as done in most large hospitals.[1]

Only one hospital reported that dressings are included in the room rate, and no hospital routinely includes medications in the stated room charge, although in one hospital such minor items as sulfonamide drugs and vitamin preparations are administered without extra charge. In one hospital, these minor drugs are charged for at the rate of $1.50 per medical or surgical patient. Administrators of two of the hospitals making separate charges for dressings indicated they would just as soon switch to the inclusive rate for these items. One administrator is comtemplating instituting a flat rate for ten days of care for surgical patients, this rate, approximately eighty dollars, would include everything.

The actual charge made for ordinary dressings in most cases is inclusive rather than individual. Only one hospital makes a separate charge for every gauze sponge applied, five cents for a small sponge and eight cents for an abdominal pad. While one-half of the hospitals studied make daily charges for dressings, the other one-half charge per dressing. The average charge by the day is seventy cents, and by the dressing forty cents. It

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[1] See Table 5

is customary to dress the patient only once a day, except in unusual cases. In no case, has an accurate study been made of the actual cost of dressing material. In three hospitals, an additional charge is made for perineal pads for obstetric patients. In one hospital, these pads are furnished by the patient.

Only three hospitals listed charges for elastic bandages, used mostly for sprains, the others apparently purchased these items directly from the drug store and charged whatever the cost directly to the patient's account.

With reference to the individual drug lines, two hospitals make no charge to the patient for parenteral solutions; the rest make a separate charge for solution administered. The amount of these charges differ widely from hospital to hospital. In one hospital, the charge for each item is its purchase price to the hospital. In another, the charge is purchase price plus 1p per cent. The others charge from $2.00 to $5.00 per 1000 cc.

Three hospitals make no charge to the patient who requires narcotic drugs. One hospital include this charge in the $1.50 charged for miscellaneous or routine drugs. The others charge a stated price, usually ten cents a dose.

No hospital gives penicillin or streptomycin to patients without making an individual charge for the drug. In the case of penicillin, the rates range from seventy-five cents to $2.50 per 100,000 units. This wide range would indicate that the drug is not being charged for on a cost basis, considering the tremendous drop in wholesale price of penicillin during the past

three years.

Streptomycin, an expensive drug comparatively, is charged for at slightly above cost. The administrators are of the belief that persons requiring streptomycin are usually least able to pay for it. A majority of the hospitals charge for sulfa drugs by the tablet, the price varying from three cents to ten cents.[1]

There seem to be no definite basis for charging insulin and liver extract. While one hospital charge for insulin and liver extract by the bottle, another charge per cubic centimeter and another charge by the injection. The average is approximately forty cents per cubic centimeter for insulin. In case of liver extract, prices charged vary from 25 to 60 cents per cubic centimeter and from 50 cents to $1 per injection.

In three of the hospitals, it was found that one or more drugs were being charged at less than cost. In one hospital, no charge was being made for Ergotrate, which cost roughly, eighteen cents per tablet. In another, Coramin was being charged for at ten cents per ampule, while it cost more than twenty cents per ampule. In still another, Demoral, which cost better than sixteen cents per ampule, was not charged for.

In none of the hospitals was charges for use of the operting room, delivery room and x-ray room based on a cost analysis. Operating room charges range from $12 to $18 for major operations. Delivery room charges range from $10 to $16. In most instances,

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[1] See Table 5

these charges have been increased within the last three years. When asked what was the basis for the increases, the administrators cited the increased cost of gauge and linens, but no actual figures were available in any case.

In only two of the hospitals are there full-time x-ray technicians. By and large, there is not enough work to warrant a full-time x-ray technician as such. Likewise, in only two hospitals are nurses assigned exclusive to the operating room, and in none of the hospitals is a nurse on delivery room duty exclusively. This makes it difficult to cost analyze these services.

CHAPTER V

HOSPITAL STATEMENT OF REIMBURSABLE COST

A treatise on fiscal systems of Negro privately-owned hospitals would be incomplete without some mention of the Hospital Statement of Reimbursable Cost. All seven of the hospitals studied are giving patient care under one or more of the following state and federal aid programs:

1. Vocational Rehabilitation
2. State Cancer Clinic
3. Crippled Children's Care

Under the Vocational Rehabilitation Program, men and women who have some correctible physical defect, such as hernia, missing limbs, cataracts, etc., and who have no money are given medical and surgical care necessary to make them self-sufficient.

Under the State Cancer Program, persons of limited means who have curable or arrestable cancer are given free treatment periodically as long as necessary.

Under the Crippled Children's Program, young children who have congenital deformities that are possible to correct are treated by bone specialists and given hospital care. Some of them are confined to the hospital for as much as three years.

In the case of State Cancer patients, the state pays the hospital seven dollars per day for each cancer patient assigned to the hospital.

The per diem rate for Vocational Rehabilitation patients and Crippled Children patients is based on the hospital's

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[1]See Appendix

computed cost to maintain a patient for one day. The Hospital Statement of Reimbursable Cost is prepared for this reason. It's importance is attested to by the fact that of the patients admitted to Hospital A, Hospital B and Hospital C in 1946, 35%, 50% and 10% respectively, were paid for by one of the agencies mentioned above.

CHAPTER VI

CONCLUSION

The fiscal systems maintained by the hospitals studied are inadequate to the extend that they are not broad enough to permit cost analysis of drugs, services and routine patient care. In some cases, the systems are encumbered with the recording of unnecessary information and the use of excess physical records.

There is no uniformity or record-keeping among the hospitals of this group.[1] This lack of uniformity hinders mutual aid in improving the systems. Each of these hospitals would profit from the purchase of "Hospital Accounting and Statistics", a manual for American hospitals with special references to small hospitals. This book is published by the American Hospital Association. The uniform system of hospital accounting set forth in this manual is simplified enough to be understood and followed by anyone of ordinary intelligence and a bare minimum of bookkeeping knowledge. Yet, it is broad enough to give all the financial data the administrator needs to intelligently coordinate his work.

A further hindrance to improving the fiscal systems of these hospitals is the desire of their owners and administrators to keep their operating expenses, income and financial policies in strict secrecy. This desire for secrecy, the student does not understand, inasmuch as each hospital submits a Hospital

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[1] See Table 7

Statement of Reimbursable Cost to the state in which it is located. This statement is public property and may be scrutinized by anyone upon request.

This desire for secrecy is also one of the reasons for the lack of trained, competent personnel. The administrators, seemingly, prefer to trust the record-keeping to untrained members of their family rather than hire trained outsiders and let them know the financial status of the hospitals. The close family connections that exist in the Negro privately-owned hospitals further discourage trained business personnel from seeking employment in this field. There seems to be no possibility of advancement beyond the position of secretary.

Because of inadequate fiscal records and untrained personnel, the pricing of drugs, dressings and services cannot be done on a cost basis, and consequently is pure guess work.

In spite of poor fiscal systems and untrained personnel, The Negro privately-owned hospital continues to operate. This, I believe, is due to several factors. The state and federal programs that send patients to the hospital, assures it of a steady flow of income. The semi-monopoly enjoyed, ill treatment experienced by Negroes in most of the white hospitals, and the fact that Negroes of means often cannot get into the city hospital, give the patient little choice as to hospitals. Finally, the use of outside accounting agencies, keep the fiscal system in some semblance of form, and provide for the preparation of the Hospital Statement of Reimbursable.

TABLE 1

TOTAL EXPENSE BREAKDOWN FOR SIX OF THE SURVEYED HOSPITALS

HOSPITAL	A	B	C	D	H	I
Total Expenses	$64,909	$59,187	$36,484	$20,561	$58,839	$19,553
Administrative	5,039	5,792	4,775	5,208	2,435	10,302
Dietary	15,181	8,919	6,739	5,890	8,757	2,571
Laundry	1,980	1,345	1,333	1,200	4,077	911
Housekeeping	1,484	1,727	2,680	----	8,107	----
Heat, Light, Etc	1,325	3,280	1,371	830	3,138	801
Maintenance	1,936	815	1,162	2,000	3,209	787
Motor Expense	136	3,039	781	150	----	---
House Physician	1,800	12,681*	----	----	4,453*	4,178*
Supplies	2,922		3,358	2,400		
Anesthesia	3,400		1,770	120		
Nursing	21,068	17,734	8,117	1,500	24,114	----
X-Ray	1,219	2,246	1,367	----	390	----
Laboratory	1,489	802	409	----	158	----
Physical Therapy	413	79	----	----	----	----
Depreciation	3,563	----	715	1,163	----	----
Rentals	1,950	----	179	----	----	----

*Contains the charges for Supplies and Anesthesia

---- No figures given by the hospital

TABLE 1a

TOTAL EXPENSE BREAKDOWN FOR SIX OF THE SURVEYED HOSPITALS
PERCENTAGE BASIS

HOSPITALS	A	B	C	D	H	I
Total Expenses	100.0	100.0	100.0	100.0	100.0	100.0
Administrative	7.8	9.8	13.1	25.4	4.1	52.7
Dietary	23.4	15.1	18.5	28.7	14.8	13.1
Laundry	3.1	2.3	3.7	5.7	6.9	4.7
Housekeeping	2.3	2.9	7.4	---	13.8	---
Heat, Light, Etc.	2.0	5.5	3.8	4.2	5.3	4.1
Maintenance	3.0	1.4	3.3	9.8	5.5	4.0
Motor Expense	0.2	5.1	2.2	0.8	---	---
House Physician	2.8	21.4*	---	---	7.6*	21.4*
Supplies	4.5		9.3	11.8		
Anesthesia	5.2		4.9	0.6		
Nursing	32.4	30.0	22.4	7.4	41.0	---
X-Ray	1.9	3.8	3.7	---	0.7	---
Laboratory	2.3	1.4	1.2	---	0.3	---
Physical Therapy	0.6	1.3	---	---	---	---
Depreciation	5.5	---	2.0	5.4	---	---
	3.0	---	0.5	---	---	---

*Contains the charges for Supplies and Anesthesia
---- No figures given by the hospital

TABLE 2.

BREAKDOWN OF PATIENT'S DOLLAR--YEAR ENDING DECEMBER 31, 1946
HOSPITAL C

Administrative Expenses	$ .14
Nursing Service	.29
Dietary	.27
Housekeeping	.07
Heat, Light, Power, Telephone and Water	.06
Laundry	.04
Maintenance and Depreciation	.04
Household Supplies	.06
Surplus (earmarked for improvements)	.03
	$1.00

TABLE 3.

COST TO MAINTAIN PATIENT FOR ONE DAY (FOOD AND ROUTINE CARE)
YEAR ENDING DECEMBER 31, 1946--HOSPITAL C

Administrative Expenses	$ .63
Maintenance and Depreciation	.26
Dietary	1.20
Nursing Service	1.29
Housekeeping	.31
Heat, Light, Power, Etc.	.26
Laundry	.19
Total Cost	$4.14

TABLE 4

SOURCES OF INCOME--YEAR ENDING DECEMBER 31, 1947
HOSPITAL C

Room and Board		
Ward (2,846 patient days @ $4.50)		$12,807.00
Semi-Private (495 patient days @ $5.50)		2,722.50
Private (472 patient days @ $6.50)		3,078.00
		18,597.50
Government Agencies		
Rehabilitation (209 patient days @ $5.27)	$1,101.43	
State Cancer Clinic (114 days @ $6.00)	684.00	
Emergency Maternity Care (60 days @ $5.27)	316.20	2,101.63
Operating Room Service		2,890.50
Anesthesia		1,845.00
Delivery Room Service		830.00
Drugs		2,464.51
Dressings		265.99
X-Ray Service		480.00
Laboratory		494.50
Blood Transfusions		116.00
Ambulance		10.00
Oxygen		46.30
Casts		50.00
Baby Oil		2.50
Birth Certificates		38.00
Telephone Calls		9.22
		30,241.65
Uncollected		1,083.06
Net Income from All Sources		$29,157.69

TABLE 5

STATED DRUGS AND DRESSING CHARGES IN SURVEYED HOSPITALS

Item	Highest Charge	Lowest Charge	Average Charge
Sponges and Pads	$1.00 per day	$0.25 per day	$0.70 per day
Elastic bandage	3.00	1.25	1.97
Parenteral solution	5.00 1000cc	2.00 1000cc	3.40 1000cc
Barbiturates	0.10 per dse	0.03 dose	0.08 dose
Penicillin	4.00 100,000	0.50 100,000	1.78 100,000
Streptomycin	8.00 gm.	3.33 gm.	5.13 gm.
Sulfonamides	0.10 tab.	0.03 tab.	0.06 tab.
Vitamins	0.15 tab.	0.05 tab.	0.11 tab.
Liver extract	0.60 cc	0.25 cc	0.40 cc

TABLE 6.

HISTORICAL AND BASIC FINANCIAL DATA CONCERNING SIX HOSPITALS SURVEYED

HOSPITAL	A	B	C	D	F	G
Opened	1945	1928	1928	1938	1901	1912
Ownership	NPA*	CORP**	NPA	NPA	NPA	NPA
Beds***	50	40	32	25	140	160
Patient Days***	17,000	15,000	3,976	6,068	30,193	38,714
Plant Value***	$75,000	$100,000	$50,000	$100,000	$562,295	$658,175
Patient Income***	$110,000	$90,000	$30,000	$100,000	----	$500,000
Gifts***	$3,000	-----	$10,000	-----	$9,000	$16,000

*Non-profit association or non-profit corporation
**Corporation, not restricted as to profit
***Figures are for 1947
---- No data given

TABLE 7

COMPILATION OF UNCLASSIFIED DATA OBTAINED FROM QUESTIONNAIRES MAILED TO HOSPITALS STUDIED

A.	Bookkeeping is done by:	Nurse	1
		Bookkeeper (untrained)	3
		Parttime bookkeeper (trained)	2
		Fulltime bookkeeper (trained)	2
B.	Bookkeeping records consist of:		
		Cash receipts and cash disbursements book	2
		Complete set including general ledger and journal	5
C.	Food purchases are made by:	Doctor	1
		Manager	2
		Nurse	2
		Dietitian	2
D.	Drugs are purchased by:	Pharmacist	1
		Doctor	2
		Manager	2
		Nurse	3
E.	Replacement of equipment		
		Value reduced annually and reserve set up	2
		Purchased from earning	4
		Solicitations from public	2
F.	Cost analysis prepared by:	C. P. A.	4
		Bookkeeper	1
		Office Manager	1
		No answer	2
G.	Charges are based on:	Cost	4
		Arbitrary	3
H.	Tax reports are filed by:	C. P. A.	2
		Employee	2
		None filed	3
I.	Depreciation and replacement of building		
		Value reduced annually and reserve set up	2
		Replaced by gifts	2
		No provision	3

TABLE 8

COMPILATION OF UNCLASSIFIED DATA OBTAINED FROM QUESTIONNAIRES MAILED TO HOSPITALS STUDIED

	QUESTIONS	YES	NO
A.	Are small purchases carefully recorded?	4	3
B.	Are your records checked by an outside source?	5	2
C.	Is a petty cash book kept?	4	3
D.	Are you receiving patients under the State program?	7	0
E.	Do you feel that your records are adequate?	2	4
F.	Do you prepare a budget at the beginning of the year?	2	5

CHART 1

PER CENT OF OCCUPANCY OF FIVE SURVEYED HOSPITALS

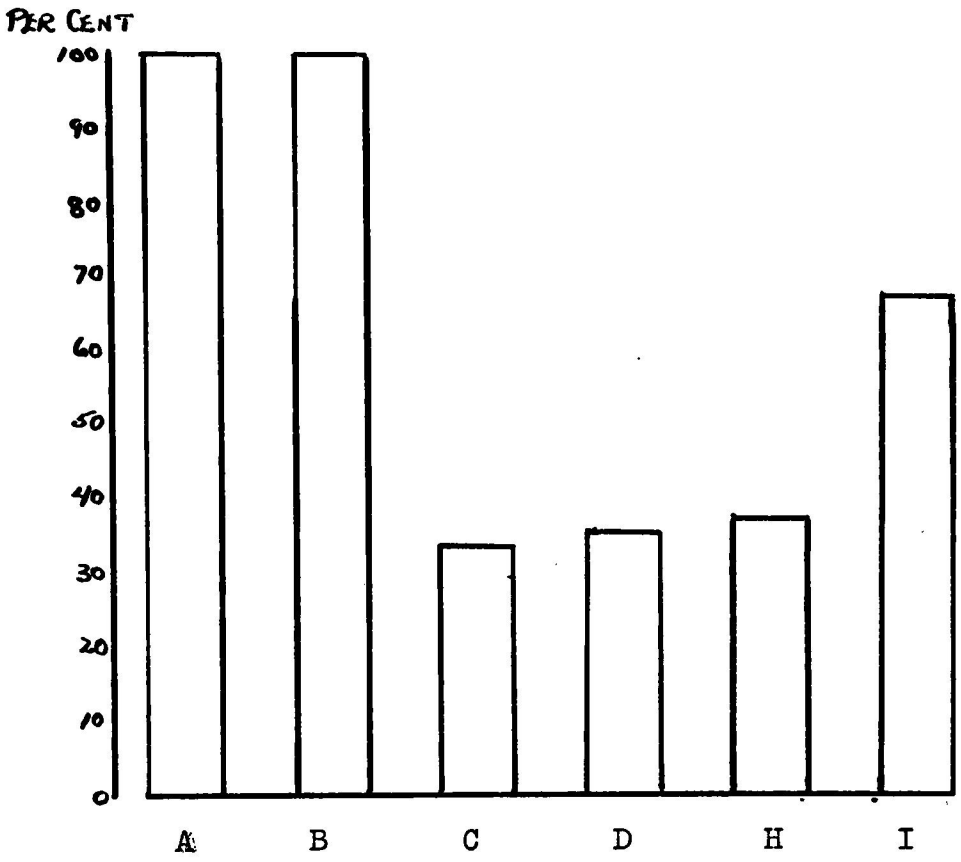
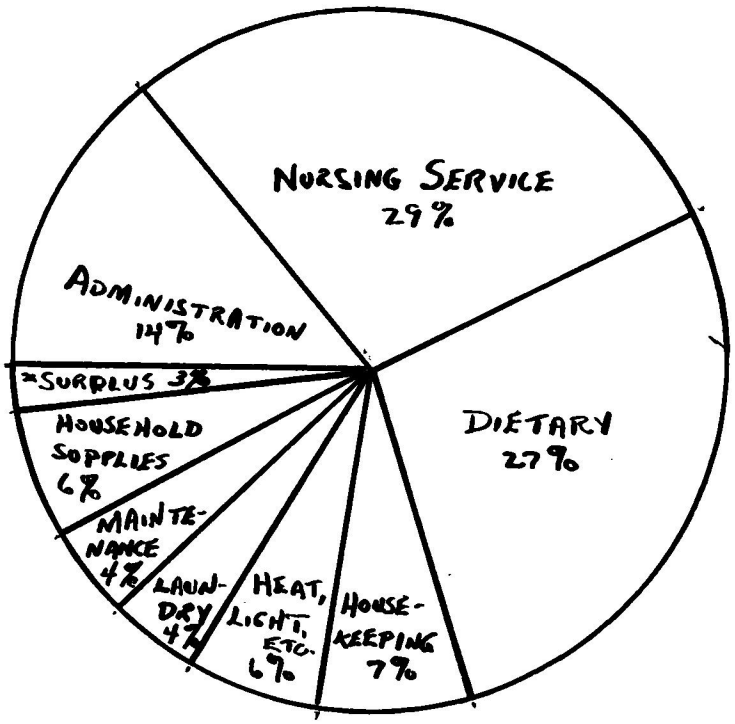


CHART 2

GRAPHIC BREAKDOWN OF PATIENT'S DOLLAR
HOSPITAL C - 1946



*Earmarked for improvement

FIGURE 1

SAMPLE ESTIMATION SHEET

A relative of yours is now a patient in _____ Hospital. You can rest assured that he or she will receive the best of care.

Our rates are as follows:

Ward $_____ per day

Semi-Private $_____ per day

Private $_____ per day

Operating Room $_____

Delivery Room $_____

Anesthesia $_____

Drugs and Dressings - as used

Method of payment: Probable bill $_____

In advance - one week's room and board, operating room and anesthesia fees.

In your case, that will amount to $_____

BALANCE - payable each week in advance.

The patient's hospital bill is to be paid in full before he or she leaves the hospital.

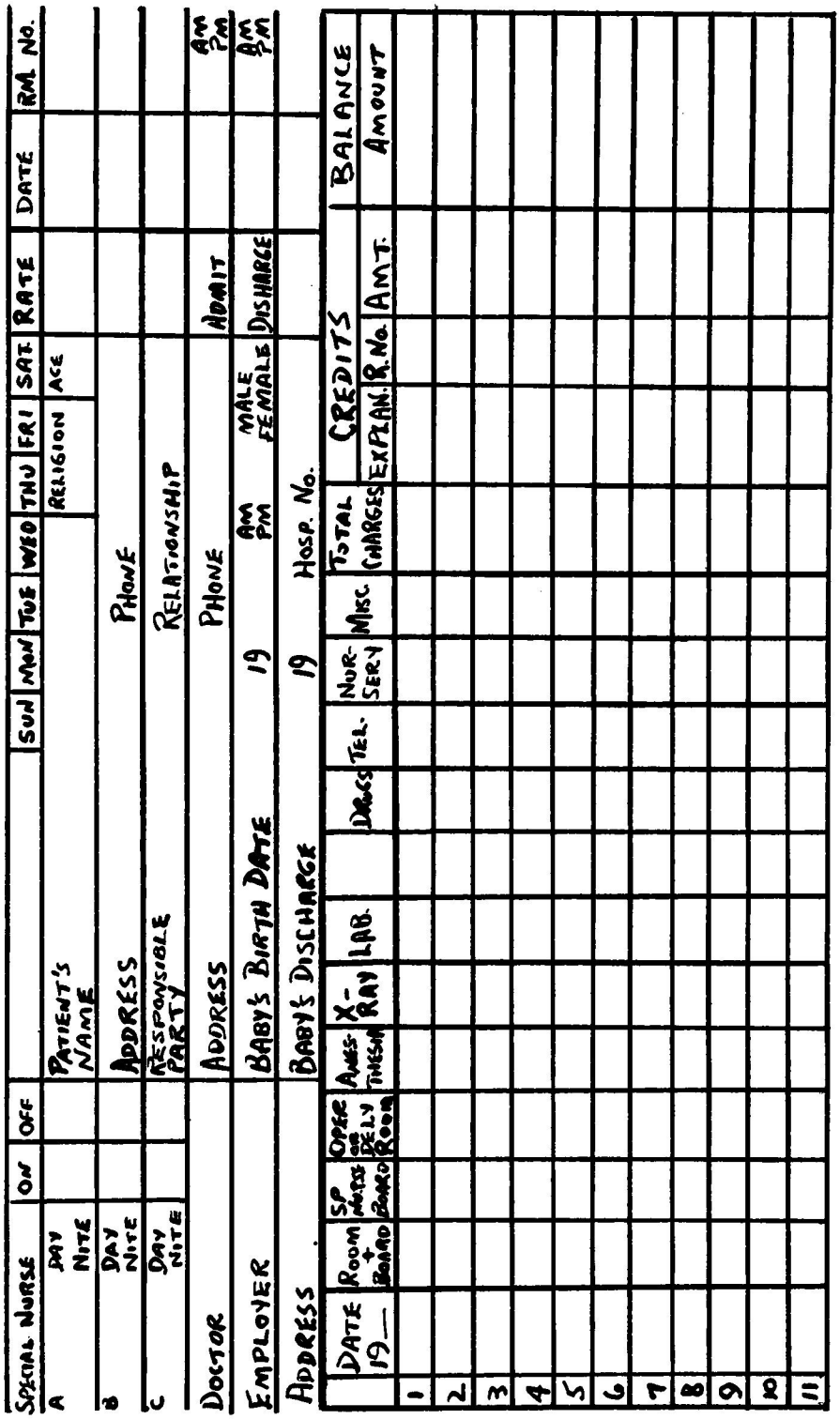
Patients leaving the hospital after the office is closed and have a refund due, will be mailed a check for same.

Visiting hours are from _____ and from _____ each day.

THANK YOU SINCERELY

FIGURE 2

SAMPLE PATIENT'S LEDGER CARD



APPENDIX

SAMPLE HOSPITAL STATEMENT OF REIMBURSABLE COST

HOSPITAL STATEMENT OF REIMBURSABLE COST

Nov. 30, 1948

Name of Hospital: Blanck Hospital, Inc.

Address: Doe Street, Other Town, Georgia

Period: October 1, 1947, to September 30, 1948

This hospital hereafter will submit a statement of reimbursable cost every (check interval that hospital elects): x 12 months. __ 6 months

A. TYPE OF HOSPITAL

1. Type of control:

Government

__ State
__ County
__ City
__ City-County

Nonprofit organization

__ Church related--Catholic
__ Church related---Other
X Nonprofit associations

Proprietary

__ Individual or partnership
__ Corporation

Type of service:

__ (a) General

__ (b) Special
- Maternity
- Children's
- Orthopedic
- Isolation
- Convalescent
- Nervous & Mental
- Tuberculosis
- Other (specify)

B. STATISTICAL DATA

Hospital personnel (computed on a full-time basis):

1. Average number of employees on hospital pay roll each month	17
2. Average number of Sisters (or members of other religious orders) who served in the hospital each month	0

In-patient statistics:

3. Beds available at beginning of accounting period	32
4. Beds available at end of accounting period	32
5. Total bed-days for the accounting period	11,680
6. Total in-patient days	3,976
(a) Newborn-infant days	577
7. Percent occupancy	34%
8. Discharges, including deaths	482
9. Average length of stay	8.3

TOTAL OPERATING EXPENSES

1.	Total amount of expenses per books	$36,484.44
2.	Expenses to be deducted	none
	(a) Research expense and medical education	
	(b) Cost of gift shops, lunch counters, etc.	
	(c) Cost of guest meals or meals paid for by employees	
	(d) Cost of telephone and telegraph charges paid for by patients, guests, etc.	
	(e) Cost of drugs or supplies purchased by individuals not admitted as patients	
	(f) Bad debts or provision therefor	
	(g) Expenditures for remodeling and equipment and fixtures	
	(h) Estimated value of donated or voluntary services	
	(i) Interest expense on capital indebtedness	
	(j) Rentals on nonhospital facilities, real-estate taxes on nonhospital lands	
	(k) Others (specify)	
3.	Total amount of hospital expenses applicable to in-patient services	$36,484.44

D. HOSPITAL EXPENSES FOR CALCULATING REIMBURSABLE COSTS

Operating Expenses

1.	Administration	$4,775.68
2.	Dietary	6,739.87
3.	Laundry	1,332.65
4.	Housekeeping	2,679.97
5.	Heat, light, power, water	1,371.49
6.	Maintenance and repairs	1,161.50
7.	Motor service	781.25
8.	Medical and surgical services	
	(a) Salaries of physicians, surgeons, house staff	
	(b) Supplies and miscellaneous	3,358.06
	(c) Anesthesia service	1,770.00
9.	(a) Nursing service	8,116.84
	(b) Nursing education	
10.	Medical records and library	
11.	Social service	
12.	X-ray (a) Diagnostic	1,367.40
	(b) Treatment	
13.	Laboratories	409.00
14.	Pharmacy	
15.	Physical therapy	

D. HOSPITAL EXPENSES FOR CALCULATING REIMBURSABLE COSTS*Cont.

17.	Total Operating Expenses	$33,863.71
	Other Allowable Expenses	
18.	Depreciation	
	(a) Building (cost of property $29,500.00	590.00
	(b) Fixtures (cost of fixtures $2,500.00	125.00
	(c) Equipment (cost of equipment $17,372.00	1,737.20
19.	Real estate taxes on property used for hospital purposes	168.50
20.	Rentals on buildings used for hospital purposes	
21.	Total, items 18, 19, and 20	2,620.70
22.	Total hospital expenses (item 17 plus item 21; should equal item c-3)	36,484.41
23.	Less: Any subsidy from Federal funds (direct or through State agencies; Salaries of personnel, etc., (enter amount chargeable	none
24.	Total hospital expenses for calculating reimbursable cost	$36,484.41

E. CALCULATION OF REIMBURSABLE COST OF IN-PATIENT SERVICE

1.	Total amount of hospital expenses for in-patient service (item D-24, column)	$36,484.41
2.	Number of in-patient days (item B-6)	3,976
3.	Average computed per diem reimbursable cost (E-1 divided by E-2) (subject to maximum rate established by State agency)	$9.18
4.	85% of calculated rate (Rate used when hospital's per cent of occupancy is less than 50%)	$7.80

F. CALCULATION OF REIMBURSABLE COST OF OUT-PATIENT VISIT

1.	Amount of hospital expenses for out-patient services (item D-24	none
2.	Number of out-patient visits	none
3.	Average computed reimbursable cost per visit (subject to maximum rate established by state agency)	none

FORM OF CERTIFICATION BY OFFICER OF HOSPITAL

I, John Doe, Business Manager, of the Blanck Hospital,

Other Town, Georgia

do certify that I have examined the accompanying statement of total expenses, the allocation thereof between in-patient and out-patient services, and the calculation of reimbursable cost of in-patient service per patient-day and of out-patient service per visit for the hospital for the year ended September 30, 1948, and that to the best of my knowledge and belief it is a true and correct statement prepared from the books and records of the hospital in accordance with instructions as contained in this statement.

A certification by a public accountant of the correctness of the amount entered in item C-1 (is, is not) attached.

*I certify that the hospital could not obtain the services of a public accountant to make an audit to determine the total expenses of the hospital during the period.

I further certify that the records of the hospital for the period covered by the operating statement were maintained on the (accrual, cash, or modified cash) basis.

(Signed) John Doe
Officer or Superintendent

November 30, 1948 Business Manager

*Delete this sentence if certification by public accountant is attached.

H. FORM OF CERTIFICATION BY PUBLIC ACCOUNTANT

I hereby certify that the amount $_____ shown in item C-1 of the accompanying statement of total expenses of Blanck Hospital, Inc., Other Town, Georgia, for year ended September 30, 1948, is correct in accordance with my audit of the books and records of the hospital after giving effect to all adjustments resulting from my examination of the books of the hospital, and to the instructions contained in this statement.

My examination was made in accordance with generally accepted auditing standards applicable in the circumstances and it included all procedures that I consider necessary (except as qualified below).

The amount entered in item C-1 (includes, excludes) items listed under item C-2.

Signature_____

LIST OF NEGRO PRIVATELY-OWNED HOSPITALS IN AREA STUDIED GEORGIA, ALABAMA AND FLORIDA

Georgia

William A. Harris Memorial Hospital, Atlanta

Gillespie Hospital, Cordele

St. Luke's Hospital, Macon

Charity Hospital, Savannah

Georgia Infirmary, Savannah

McLendon Clinic, Atlanta

Alabama

Children's Hospital, Birmingham

Fraternal Hospital, Montgomery

Burwell Infirmary, Selma

John Andrew Memorial Hospital, Tuskegee Institute

Talladega Infirmary, Talladega

Florida

Brewster Hospital, Jacksonville

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